

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**COMBUNOX** (ibuprofen / oxycodone HCL 400mg -5mg)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext. and options \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**CRITERIA:**

Components must be unavailable separately

**AUTHORIZATION:**

Telephone call by Pharmacy or Provider to (801) 538-6155.

Prescriptions for 4 tablets daily or less, for 7 days only.

**RE-AUTHORIZATION:**

Requires new request, neither of the components are available separately.

Prescriptions for 4 tablets daily or less, for 7 days only.